5305

# Association of Connecticut Ambulance Providers

Aetna Ambulance -:- Ambulance Service of Manchester -:- American Ambulance Service
American Medial Response -:-Campion Ambulance Service -:- Hunter's Ambulance Service

Testimony of
David D. Lowell, President
Association of Connecticut Ambulance Providers

Insurance and Real Estate Committee

Tuesday, March 02, 2010

Senator Crisco, Representative Fontana and distinguished members of the Committee.

My name is David Lowell. I am President of the Association of Connecticut Ambulance Providers.

I am speaking today on behalf of our membership in opposition of House Bill No. 5305, ***An Act Exempting from Regulation Certain Nonprofit Volunteer Ambulance Services or Companies.***

It is our position that this bill is not needed and significantly upsets the balance of Connecticut's Emergency Medical Services (EMS) system. Connecticut's Emergency Medical Services System is a balanced network of volunteer, municipal, private and not-for-profit service providers. The system was developed in the 1970's to provide structure and set quality standards for the delivery of emergency medical care and transportation. The system has the integrity of high quality care and vehicle and equipment safety accountability through three related and essential components of our regulations:

- Rate Setting and Regulations.
- Certificate of Need Process.
- Primary Service Area Assignments.

Volunteer ambulance services are classified as "Certified". This definition limits their scope of operation to emergency response only. Non emergency transports are performed by "licensed" ambulance services that are also permitted to provide emergency response and transport.

Nearly 85 % of all volunteer certified ambulance services charge for their service using a regulated rate structure approved annually by the department of public health. This means that these certified services bill the Medicare and Medicaid programs as well as commercial insurers for both primary and secondary insurance reimbursement. Medicare has taken a very strict stance on the concept of subscription or membership programs (refer to attachment A letter from the Department of Health and Human Services General Counsel).

The Department of Health and Human Services (currently referred to as the Centers for Medicare and Medicaid Services [CMS]) issued a position statement in 1991 that qualifies the risks inherent with subscription programs as potentially illegal.

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With regard to the establishment of subscription or membership fees charged by an ambulance company in lieu of co pays and deductibles, the General Counsel of Health and Human Services Michael J. Astrue (1991, p. 2) wrote: "The OIG has found that, in order to be less obvious about routinely waiving coinsurance and deductible fees, some providers have established phony "insurance programs." Under these programs, providers charge nominal premiums to cover the copayments and deductibles so long as the items or services are ordered from that provider. These "premiums" are often very small and are not based on a good faith assessment of actuarial risk. Rather, these insurance programs are simply a disguise for illegal routine waiver of coinsurance and deductibles. " (Astrue, Michael J., Letter to the Honorable Lawerence J. DeNardis, President-Designate, University of New Haven. 1991.).

In the March 24, 2003 publication of the Federal Register, Volume 68, Number 56, page 14253 (Attachment B) The document states: "Subscription or membership programs that offer patients purported coverage only for the ambulance supplier's services are also problematic because such programs can be used to disguise the routine waiver of cost-sharing amounts. To reduce their risk under the anti-kickback statute, ambulance suppliers offering subscription programs should carefully review them to ensure that the subscription or membership fees collected from subscribers or members, in the aggregate, reasonably approximate-from an actuarial or historical perspective-the amounts that the subscribers or members would expect to spend for cost-sharing amounts over the period covered by the subscription or membership agreement." (Axelrad, Jane A., March 24, 2003, Federal Register/ Vol. 68, No. 56, P. 14245)

It is the position of the our association that the introduction of a "subscription" program in our state In any form given the comprehensive regulatory balance of rate setting, certificate of need and primary service area assignment is not appropriate. On nearly a daily basis, our companies are called upon to provide mutual aid ambulances to single ambulance volunteer and municipal communities to assist them in handling multiple emergency calls. Our companies would have no knowledge of the subscription status of an individual resident and would be compelled to follow the normally accepted billing and reimbursement practices. Our experience indicates that there are a small percentage of insurance companies that don't cover the full cost of an emergency ambulance transport. Additionally, if a volunteer service does not bill for services, there is a mechanism in place for them to obtain an approved rate schedule through the department of public health and bill and be compensated for their services in the community. This process would fall in line with all other provider types and maintain the system balance and continuity of care across the state.

In closing, I urge the committee to not support this bill as we believe it will disrupt the balance of the emergency medical services system in our state.

Respectfully Submitted,

David D. Lowell
President

ATTACHMENT A-1

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The General Counsel
Washington, D.C. 20201

AUG 14 1991

The Honorable Lawrence J. DeNardis
President-Designate
University of New Haven
300 Orange Avenue
West Haven, CT 06516

Dear Larry,

This letter is in response to your recent call and Mr. Werfel's June 14, 1991 letter concerning ambulance subscription agreements. You state that it is common for ambulance companies to offer subscription agreements (also known as membership plans) to Medicare beneficiaries. Under such an agreement, the ambulance company charges an annual fee (typically $40-$50 per household) and agrees to accept assignment of all claims for medically necessary services. The ambulance company does not bill the beneficiary for the coinsurance or deductible. You state that the annual membership fee is treated as the amount that would have been paid for coinsurance and deductibles. You suggest that the subscription fees are, in effect, premiums for coverage by the ambulance company of coinsurance and deductible fees. You question whether this practice is legal in light of the Office of Inspector General's (OIG's) Special Fraud Alert on Waiver of Copayments and Deductibles Under Medicare Part B.

As explained in the Special Fraud Alert, Medicare patients are generally responsible for paying an annual Medicare deductible and then a copayment for each item or service paid for by Medicare. There are several purposes to this requirement, including sharing costs between Medicare and beneficiaries, and encouraging patients to be better health care consumers by giving them a financial stake in their health care decisions. Unfortunately, however, some providers routinely waive collection of coinsurance and deductibles. Providers often waive these fees as a marketing technique, to encourage Medicare beneficiaries to use a particular provider, and to order items and services on the theory that they are "free" because the beneficiaries incur no-out-of-pocket expense. This, unfortunately, leads to the ordering of many unnecessary items or services for which the Medicare Part B program must pay. In our view, this practice if unlawful under the anti-kickback statute, 42 U.S.C. § 1320a-7b(b) and the Civil Monetary Penalties statute, 42 U.S.C. § 1320a-7a.

The OIG has found that, in order to be less obvious about routinely waiving coinsurance and deductible fees, some providers have established phony "insurance programs." Under these programs, providers charge nominal premiums to cover the copayments and deductibles so long as the items or services are ordered from that provider. These "premiums" are often very small and are not based on a good faith assessment of actuarial risk. Rather, these insurance programs are simply a disguise for illegal routine waiver of coinsurance and deductibles.

Therefore, in analyzing the legality of the subscription agreements discussed in your letter, it would be necessary to determine whether the amounts charged as "premiums" by the ambulance companies are a reasonable assessment of the actuarial risk faced by these companies. In other words, it would be necessary to determine whether the amounts charged as premiums are a reasonable approximation of the amounts that an average beneficiary would expect to spend for copayments and deductibles over the period covered by the subscription agreement. If the answer to this question is no, then we would likely view the membership plans as an illegal practice designed to disguise routine waiver of Medicare Part B coinsurance and deductibles.

You attached to your inquiry a June 3, 1986 letter from Elmer W. Smith, Director, Office of Eligibility Policy, Health Care Financing Administration, and a copy of section 2306(E) of the Medicare Carriers Manual. As you know, Mr. Smith's letter states that he is not in a position to render an answer on whether these subscription agreements violate the anti-kickback statute nor, as you point out, does section 2306(E) of the Medicare Carriers Manual discuss that issue.

Thank you for your interest in exploring this issue.

Sincerely,

Michael J. Astrue
General Counsel

cc: David Werfel

contemplating such arrangements should consider obtaining an OIG advisory opinion. While cities and other EMS sponsors may charge ambulance suppliers amounts to cover the costs of services provided to the suppliers, they should not solicit inflated payments in exchange for access to EMS patients, including access to dispatch services under "9–1–1" or comparable systems.

A city or other political subdivision of a state (*e.g.*, fire district, county, or parish) may not require a contracting ambulance supplier to waive copayments for its residents, but it may pay uncollected, out-of-pocket copayments on behalf of its residents. Such payments may be made through lump sum or periodic payments, if the aggregate payments reasonably approximate the otherwise uncollected cost-sharing amounts. However, a city or other political subdivision that *owns and operates* its own ambulance service is permitted to waive cost-sharing amounts for its residents under a special CMS rule. (See CMS *Carrier Manual*, section 2309.4; CMS *Intermediary Manual*, section 3153.3A; see also, *e.g.*, OIG Advisory Opinion No. 01–10 and 01–11.)

*b. Ambulance Restocking*

Another common EMS arrangement involves the restocking of supplies and drugs used in connection with patients transported to hospitals or other emergency receiving facilities. These arrangements typically do not raise anti-kickback concerns. However, ambulance suppliers participating in such arrangements can eliminate risk altogether by complying with the ambulance restocking safe harbor at 42 CFR 1001.952(v). In general, the safe harbor requires that EMS restocking arrangements involving free or reduced price supplies or drugs be conducted in an open, public, and uniform manner, although hospitals may elect to restock only certain categories of ambulance suppliers (*e.g.*, nonprofits or volunteers). Restocking must be accurately documented using trip sheets, patient care reports, patient encounter reports, or other documentation that records the specific type and amount of supplies or drugs used on the transported EMS patient and subsequently restocked. The documentation must be maintained for 5 years. The safe harbor also covers fair market value restocking arrangements and government-mandated restocking arrangements. The safe harbor conditions are set forth with specificity in the regulations.

Wholly apart from anti-kickback concerns, ambulance stocking arrangements raise issues with respect to proper billing for restocked supplies and drugs. Payment and coverage rules are set by the health care program that covers the patient (*e.g.*, Medicare or Medicaid). To determine proper billing for restocked supplies or drugs, ambulance suppliers should consult the relevant program payment rules or contact the relevant payment entity. Under the Medicare program, in almost all circumstances the ambulance supplier—not the hospital—will be the party entitled to bill for the restocked supplies or drugs used in connection with an ambulance transport, even if they are obtained through a restocking program. However, under the ambulance fee schedule, supplies and drugs are included in the bill for the base rate and are not separately billable. Ambulance suppliers should consult with their payor to confirm appropriate billing during the new ambulance fee schedule transition period.

2. Arrangements With Other Responders

In many situations, it is common practice for a paramedic intercept or other first responder to treat a patient in the field, with a second responder transporting the patient to the hospital. In some cases, the first responder is in a position to influence the selection of the transporting entity. While fair market value payments for services actually provided by the first responder are appropriate, inflated payments by ambulance suppliers to generate business are prohibited, and the government will scrutinize such payments to ensure that they are not disguised payments to generate calls to the transporting entity.

3. Arrangements With Hospitals and Nursing Facilities

Because hospitals and nursing facilities are key sources of non-emergency ambulance business, ambulance suppliers need to take particular care when entering into arrangements with such institutions. (See section F above.)

4. Arrangements With Patients

Arrangements that offer patients incentives to select particular ambulance suppliers may violate the anti-kickback statute, as well as the CMP law that prohibits giving inducements to Medicare and Medicaid beneficiaries that the giver knows, or should know, are likely to influence the beneficiary to choose a particular practitioner, provider, or supplier of items or services payable by Medicare or Medicaid. (See section 1128A(a)(5) of the Act (42 U.S.C. 1320a-7a(a)(5).) Prohibited incentives include, without limitation, free goods and services and copayment waivers. The statute contains several narrow exceptions, including financial hardship copayment waivers and incentives to promote the delivery of preventive care services as defined in regulations. In addition, items or services of nominal value (less than $10 per item or service or $50 in the aggregate annually) and any payment that fits into an anti-kickback safe harbor are permitted.

An ambulance supplier should not routinely waive federal health care program copayments (*e.g.*, no "insurance only" billing), although the supplier may waive a patient's copayment if it makes a good faith, individualized assessment of the patient's financial need.(16) Financial hardship waivers may not be routine or advertised. As discussed in section G above, cities and other political subdivisions are permitted to waive copayments for services provided directly to their residents.

Subscription or membership programs that offer patients purported coverage only for the ambulance supplier's services are also problematic because such programs can be used to disguise the routine waiver of cost-sharing amounts. To reduce their risk under the anti-kickback statute, ambulance suppliers offering subscription programs should carefully review them to ensure that the subscription or membership fees collected from subscribers or members, in the aggregate, reasonably approximate—from an actuarial or historical perspective—the amounts that the subscribers or members would expect to spend for cost-sharing amounts over the period covered by the subscription or membership agreement.

*VI. Conclusion*

This ambulance compliance program guidance is intended as a resource for ambulance suppliers to decrease the incidence of fraud and abuse as well as errors that might occur due to inadequate training or inadvertent noncompliance. We encourage ambulance suppliers to scrutinize their internal practices to ensure the development of a comprehensive compliance program.

Compliance programs should reflect each ambulance supplier's individual and unique circumstances. It has been the OIG's experience that those health care providers and suppliers that have developed compliance programs not only better understand applicable federal health care program requirements, but also their own internal operations. We are hopeful that